Early Childhood Intervention | TEXAS Health and Human Services

Referral, Physical, Prescription Form
Referral line 915 534-4ECI(4324)
Email: childfind@elpasoeci.org www.elpasoeci.org

Fax to ECI Child Find: 915 496-0750 Date faxed: _____ From: _____

ECI Fax Referral Form

Person Referring: _____ Agency: _____

Address: _____ Phone: _____

Physician: _____ Reason for Referral: _____

Child's Name: _____ DOB: _____

Race/Ethnicity: _____ Gender: Female☐ or Male☐ Primary Language: _____

Parent/Guardian: _____

Primary ph. /name: _____ Secondary Ph. /name: _____

Physical Address: _____ Zip Code: _____

Mailing Address: _____ Zip Code: _____

Physical Exam and Prescription Form

☐ **Initial** ☐ **Renewal**

Height: _____ Weight: _____lbs. Diagnoses: _____

ICD 10 Code(s) _____ Date of Physical: _____

	N	ABN	Not Done	Comments		N	ABN	Comments
Musculoskeletal					Mouth			
Extremities					Throat(teeth)			
Lymphatic					Neck			
Skin					Lungs			
Head					Heart			
Hair					Abdomen			
Scalp					Hernia			
Eyes					Genitalia			
Ears					Reflexes			
Nose					Endocrinopathics			

I hereby authorize the following as needed to be provided for this individual:

- ❑ Physical Therapy
- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ Nutrition Services
- ❑ Developmental Services

Comments/Indications/Contraindications:

Physician's Name _____ Physician's Signature _____ Date_____
(print)